A.8.0

Automation Instructions

General

This section contains instructions for entering information into the two systems used by workers to record CMS activity, the CMS IT System and IDX. Workers must also clear all CMS applications, including GR recipients, on the CMS IT System, CalWIN, MEDS, and IDX systems before approving CMS benefits.

A.8.1

CMS IT System

General

The CMS IT System is a web-based eligibility system (sdcmsapps.com). All CMS applications will be processed and maintained on the CMS IT System. All case documentation and verifications will be stored on the CMS IT System. The CMS IT System will also afford CMS contracted providers the ability to access the website to view CMS case status.

A. CMS Notices of Action (NOA)

1) NOAs requiring manual mailing

   a) Homeless
   The CMS IT System will create various NOAs and Informing Notices for homeless patients, but will not automatically mail the notices. The notices will be stored in the patient's record on the CMS IT System.

   If the patient requests a copy of their NOA or Informing Notice, the worker will be able to access the notice and print it on site for the patient. The worker shall make a narrative entry indicating the date the notice was provided, and shall specify which notice was provided.

   b) Excess Income Only Denials
   The CMS IT System will create the Excess Income Only Denial NOA, but will not automatically mail the notice. The denial NOA will be available in patient's record on the CMS IT System the following workday after the denial action was taken by the worker.

   The worker shall access the patient's record the next workday following the denial action and shall print the Excess Income Only Denial NOA. The worker shall mail the Excess Income Only Denial NOA and CMS Hardship Application (refer to Article A, Section 13) to the patient. The worker shall make a narrative entry indicating the date the notice was provided, and shall specify which notice was provided.

2) NOAs which will be automatically mailed

   a) CMS Approval

The certification period will be automatically filled in prior to the NOA being mailed.

b) Denial NOAs except Excess Income Only
Workers shall enter all case specific information applicable to the denial into the system at the time the denial action is taken (ie, what specific items the patient failed to provide, the amount the patient needs to spend down). The case specific information will be automatically filled in prior to the NOA being mailed.

B. Approval Action

Based on the applicant's/beneficiaries information entered, the CMS IT System will determine if the client is approved for CMS benefits.

All approval actions taken by the worker will remain in a "pending approval" status for a minimum of one night. Fifty percent of all approvals must be reviewed and released by a supervisor. Each night the CMS IT System will randomly select from the pending approvals, which approvals are to be reviewed by a supervisor, which pending approvals can be approved without a supervisor review.

C. Denial Action

Based on the applicant's/beneficiaries information entered, the CMS IT System will determine the appropriate denial action, generate a denial NOA and automatically mail it to applicant as appropriate. Some denial NOAs require manual mailing.

D. Credit Report Request

Worker must order a credit report at initial application, recertification or reapplication when information is received from applicant/beneficiary or circumstances are noted which could indicate the possibility of fraud. Reasonable care must be taken to input the applicant's/beneficiary's identification information accurately when requesting a credit profile report. When a case consists of a married couple, both spouses must sign the Credit Report Authorization (CMS-99). CMS will use the credit report as a verification tool for financial, property and eligibility information, which the applicant/beneficiary has provided on their application for CMS. At the end of each business day, the CMS IT System will batch and submit all credit report requests to Experian. The credit profile report is received from Experian on the following business day. Worker must follow-up with

applicant/beneficiary on discrepancies found on report. Worker must verify that all verifications/documents are provided to clear up discrepancy on report to evaluate for CMS eligibility as described in MPG Article A Sections 2 and 13. **NOTE: The credit check authorization is good for only one (1) credit report profile request.**

Credit reports obtained through the CMS IT System may not be given to the applicant/beneficiary. If the applicant/beneficiary requests a copy of their credit report, refer them to the sources listed on the Credit Check Authorization form CMS-99.

MPG Letter #665 (4/09)

A.8.2

IDX System

General

Below are instructions for recording case activity, including some of the different types of alerts, comment entries and status codes entered on the IDX system to assist staff with the processing of CMS cases. Workers must check the IDX comment and status lines for these alerts and entries and take appropriate action before issuing benefits. All CMS cases must have an IDX screen-print of both the Eligibility Summary Screen and the Comment Screen on file and documentation of the actions taken by the worker *(See Appendix A of this section for instructions on how to access the Comment Screen for complete information.).*

A. Recording Case Activity

The disposition of every CMS application and recertification is automatically communicated from the CMS IT System to IDX each night.

B. Threatening/ abusive Patient Alert

This procedure records a computer alert to County and ASO staff that a beneficiary has threatened or verbally abused clinic, County or ASO staff. It is also followed when a beneficiary disrupts clinic or worker office operations.

1) Policy

The Alert is an IDX communication tool designed to notify staff that has face-to-face contact with a beneficiary to exercise caution. The Alert may be initiated by either ASO or County staff, and is reviewed at each new application. ASO staff follows procedures similar to those outlined below. Additionally, the information contained in the Alert is for CMS staff only, and is not to be shared with the beneficiary.

2) Alert Criteria

The Alert is a notice to staff to exercise additional caution when dealing face-to-face with a beneficiary. This includes but is not limited to the following situations:

a) Beneficiary identified as a drug seeker.
b) Beneficiary made threats directed at clinic, County or ASO staff.

c) Beneficiary was verbally abusive and/or disrupted clinic or worker office operations.

3) Referral Procedure

When beneficiaries meet the above criteria the worker:

a) Emails their supervisor explaining the situation. The email must contain the Beneficiary's name, social security number and the clinic or office which the incident occurred.
b) Scan a copy of the email to the case record.
c) The Supervisor will advise the ASO to place the alert on IDX.

The above procedure is followed each time the need for a subsequent Alert is identified.

4) Mandatory Supervisor Review

The Supervisor reviews all Alert Referrals for completeness and to insure that it is an appropriate referral. When the referral is appropriate, both the email and the Alert Referral are forwarded to data entry. When the referral is inappropriate, the Supervisor notifies the originating worker.

5) IDX Entry

The Alert is entered into the comment section of the current eligibility screen and is carried forward to each subsequent eligibility screen until County staff removes the Alert. The Alert will also appear as a treatment referral containing the following:

a) Reason for referral,
b) Name of person originating the referral, and
c) Date of referral.

A new Alert Referral is created for each subsequent County or ASO Alert Referral.

6) Alert Status Review

The worker will review the Alert at each new application. The Alert status will be removed after one year if no additional Alert designations were assigned to the beneficiary during the 12-month period. To remove the Alert, the worker sends an email their supervisor requesting the alert be deleted. The Supervisor

will forward the email to data entry.

C. Alerts

The purpose of alerts is to have a means of communication between CMS Program and eligibility staff. These alerts identify patients who are no longer eligible to be recertified for CMS or that there are issues that must be resolved before recertifying CMS.

1. "Do Not Recert"

The **"Do Not Recert"** Alert is used when a patient is determined not eligible for CMS or an entry is made following the alert that the patient must comply with a program requirement. For example: "Do Not Recert" Pt failed to attend consultative exam."

The "Do Not Recert" alerts include the reason for the alert. The date and IDX user ID at the end of the entry identifies the person who placed the alert. Workers are not to recertify any case with a "Do Not Recert" alert, and narrate the reason the case is not being recerted in the case record.

2. "Call Before Recert"

The "Call before Recert" alerts have the reason for the alert, the date and the IDX user ID for the CMS Program staff who should be contacted regarding the alert. For example "Call SQ before Recert" means to call Sandra Quinonez. (*See Appendix B of this section for phone numbers, initials of name and user ID information for* CMS Program *staff).*

After the issues have been resolved, the person who placed the alert will remove it from IDX and will send an email to staff advising that alert as been lifted.

Workers must not recertify a patient without first contacting CMS Program for instructions on what actions the patient must take before issuance of benefits. <u>Workers must ensure that all issues are resolved and documented in the case narrative before recertifying CMS.</u>

Below are some examples of when these alerts are used.

a) Fraud

When the beneficiary does not cooperate with the CMS

investigation into allegations of fraud, HCA staff will place an alert to prevent recertification until the beneficiary cooperates or the investigation is complete.

b) Overpayment Collections

When the beneficiary does not cooperate in reimbursing CMS for overpayment of benefits, the Overpayment Collections Analyst will place a "Call (initials) before Recert" alert to prevent recertification until the beneficiary contacts the Analyst to discuss payment arrangements.

c) Third Party Liability

When the beneficiary does not cooperate with CMS in providing information about injuries caused by a third party or in reimbursing CMS from a third party payment, the Third Party Analyst will place an alert to prevent recertification until the beneficiary contacts the Analyst and provides the information or payment.

d) CMS Program

CMS Program staff use the **"Call (initials) Before Recert**" alert when there is a need to speak to a patient to resolve certain issues and has not been able to contact the patient.

D. Medi-Cal Status

CMS uses status codes to track the progress of Medi-Cal referrals and applications. When beneficiaries are approved Medi-Cal retroactively, CMS bills Medi-Cal for reimbursement and notifies the hospitals and clinics that they need to bill Medi-Cal for services rendered.

1) Medi-Cal Referred (Status Code A-R)

The A-R status code identifies beneficiaries who are approved CMS for three months and have been referred to apply for Medi-Cal with the form HHSA: CMS-5. The worker checks the A-R status code and writes the date of the referral in the case narrative. The beneficiary's name will be included on the A-R list that is cleared each month by CMS Program staff. Once CalWIN shows the Medi-Cal case is pending, CMS Program staff requests the ASO to change the status code to A-P.

If the beneficiary fails to apply for Medi-Cal within the three months, the ASO removes the beneficiary's name from the A-R list by changing the enrollment code to a CA status and making the entry "**Pt did not apply for MC (A-R month/year)**" in the IDX comment line.

If the beneficiary did not apply for or complete the Medi-Cal application as previously instructed, **the worker must not approve CMS** until there is compliance. There will be a "call before recert" alert. There may be situations where there may be extenuating circumstances or good cause for non-compliance. A short re-certification may be approved based upon conditional Medi-Cal compliance. This is done on a case-by-case basis after supervisor consults CMS Program Recovery for approval. CMS Recovery Program Specialist will send email to worker authorizing the short certification period. Worker must document the action in the case file.

2) Medi-Cal Pending (Status Code A-P)

This status code identifies beneficiaries who have applied for Medi-Cal and have a case pending on CalWIN. The worker writes the Medi-Cal application date in the case narrative. This code is also used when beneficiaries have a SSI application or SSI appeal pending. The worker writes the date of the SSI application or the filing date and level of the SSI appeal on the case narrative. When the beneficiary has a record on MEDS, the SSI appeal information is on the MEDS QP screen. Workers must document that they asked the beneficiary for an updated status of their Medi-Cal, Social Security application or appeal at every interview. If there is a change, the entry must be made in the case narrative.

If the beneficiary is approved for Medi-Cal, Social Security disability benefits or SSI, the worker must immediately forward this information to the Recovery Program Specialist at 0557A, by e-mail or fax. If the award letter is available, it is attached to the information; if not, the worker must ask the beneficiary to provide a copy of the award letter and forward it when received. **NOTE: Workers must not approve CMS benefits for a beneficiary that has been determined disabled who has a pending Medi-Cal case, pending SSI/Social Security Disability application or has an appeal pending at SSA Hearing level.**

3) Medi-Cal Approved (Status Code N-A)

This status code identifies beneficiaries whose Medi-Cal eligibility has been **verified** on MEDS.

E. "CHRONIC" Indicator

The ASO has the responsibility of entering a "CHRONIC" indicator on the IDX Eligibility Enrollment Summary Screen for CMS beneficiaries whose chronic medical condition has been identified and verified by claims data in IDX. Before recertifying a CMS case, eligibility staff must check the IDX Eligibility Enrollment Summary Screen for the "CHRONIC" indicator. CMS beneficiaries who have the chronic indicator on the IDX Eligibility Enrollment Summary Screen are to be recertified for twelve months if all program requirements are met. Refer to Article A, Section 7 for recertification instructions for chronics.

APPENDIX A

APPENDIX A

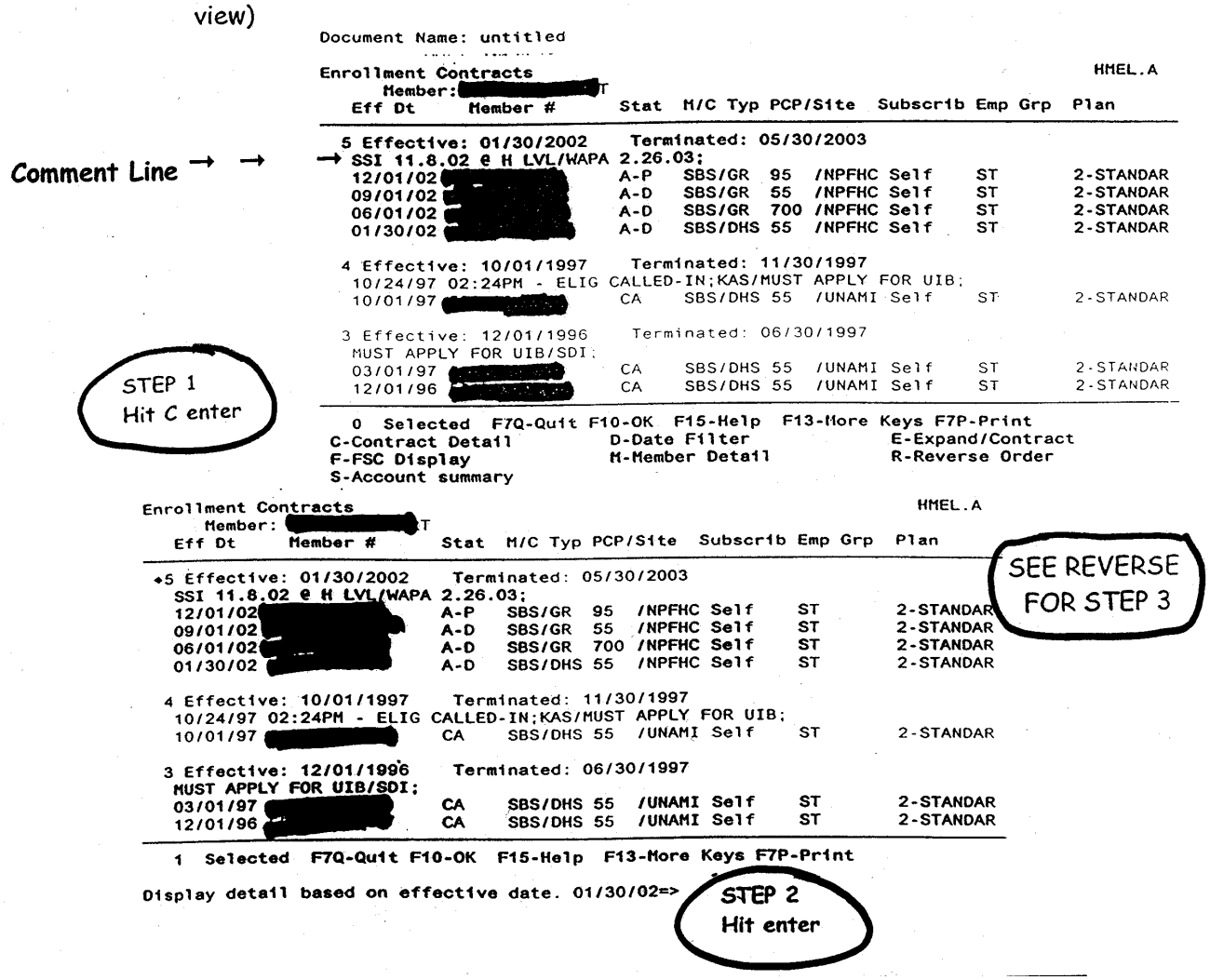
IDX Comment Screen

These are the instructions for accessing complete information in the comment section for each contract number. In this example observe how the IDX enrollment screen only shows part of the comments, but once you get to the comment screen there is more.

(1) Enrollment Screen, Have cursor on contract your working with.
Hit: C enter (contract detail)

(2) Hit: enter (displays oldest date of contract your working with)

(3) Enter: com and then hit enter (Jump to page: selecting what you want to view)



APPENDIX A

Continued: IDX Comment Screen

Document Name: untitled

[redacted]8 Screen dates 01/30/02 to 05/31/02 UMEC.

Ini: Subscrib: [redacted] Eff Dt Change: 01/30/200
Contract: 5) [redacted] End Date:

Subscriber Information

AKA Name:
MRN: [redacted]
Sex: M
DOB: 12/01[redacted]
Addr1: [redacted]N STREET
Addr2: APT [redacted]
Zip: [redacted]
City,ST: SAN DIEGO,CA
Phone: 619[redacted]

Ethnicity: CAUCASIA
Alien Ver: N
DSS#:
OHC: NO
Chronic Cond: NO
Family Size: 1
Monthly Income: 0
Empl: A
Type of Empl: E

FSC: CMS
R 1:
R 2:
R 3:
ID:
FS:
Den2:
Den3:

Contract Information

Eff: 01/30/2002 Grp: CMS
Term: 05/30/2003 Type: DHS
Appl: 03/25/2002 Plan: 2

St: A-D
Den:
Rep: SCOTT,MONICA

PCC: NORTH PARK HEALTH C
Elg: MID-CITY,COMMUNITY
Dul:

Jump to page: com

STEP 3
Enter: com and then hit enter

← ← Displays all comments entered for this contract number

↓

↓

↓

→

Document Name: untitled

[redacted] Screen dates 01/30/02 to 05/31/02 UMEC.COM

Contract Comments F10-OK F15-help Line limit: 10 lines: 5

SSI 11.8.02 @ H LVL/WAPA 2.26.03;
SSI @ R 6/22/02/ WAPA 9/9/02;
PER MC221 NOT DISABLED; SSI D 06/14/02; ASK PT IF APPEAL IS FILED; SHORT CERT/
ANTICIPATES JOB 8/1/02;
MC DED REF'D (3.25.02) SSI D N31 6.14.02;

Jump to page: